

COVID-19 and Healthcare Lessons Already Learned

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Abstract; COVID-19 has exposed deep-rooted flaws in our health system regarding healthcare financing and delivery. This essay uses COVID-19 as a frame to reflect on the growth in our uninsured population, the flaws inherent in healthcare federalism, how “Trumpcare” has made things worse, the magnified importance of Medicaid, and the problems inherent in relying primarily on private actors.

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I. Introduction

The COVID-19 pandemic has raised immensely important questions about the United States' approach to public health and healthcare finance and delivery.¹ These will be central to the post-mortem studies that inevitably will follow the pandemic. While the disease is pathologically agnostic, it has exposed America's deep economic and related racial inequalities. These are reflected by our healthcare system. However, at a more pedestrian or at least more finite level, the pandemic is highlighting and confirming deep-rooted flaws in our healthcare financing and delivery. This essay uses COVID-19 as a frame to reflect on the growth in our uninsured population, the flaws inherent in healthcare federalism, how "Trumpcare" has made things worse, the incredible importance of Medicaid, and the problems inherent in relying primarily on private actors. This is not an uplifting narrative but, hopefully will lead us to build a better system as we move forward.

II. The Uninsured and Underinsured Problems are Bad and Getting Worse

Although President Trump's 2017 claim that "Obamacare is Dead"² was plainly false, the argument that the Affordable Care Act (ACA)³ is "stuck in purgatory," suffering from decade-long injuries, and still under attack in Congress and before the courts is somewhat exaggerated⁴—or would be but for the existential threat of *Texas v. United States*.⁵ The deficiencies in the ACA that have prompted the most attention during its first decade have been

¹ Ed Pilkington & Tom McCarthy, *The missing six weeks: how Trump failed the biggest test of his life*, GUARDIAN (Mar. 28, 2020), <https://www.theguardian.com/us-news/2020/mar/28/trump-coronavirus-politics-us-health-disaster>.

² Lauren Gambino, *Trump claims 'Obamacare is dead' despite failure to repeal legislation*, GUARDIAN (Oct. 16, 2017), <https://www.theguardian.com/us-news/2017/oct/16/donald-trump-obamacare-is-dead-affordable-care-act>.

³ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

⁴ Jonathan Oberlander, *The Republican War on Obamacare - What Has It Achieved?*, 379 N. ENGL. J. MED. 703 (2018).

⁵ 945 F.3d 355 (5th Cir. 2019), *cert. granted*.

its failure to address treatment or prescription drug costs and the increasing problem of declining actuarial value in healthcare policies resulting in underinsurance,⁶ primarily for middle-income persons with insurance provided by their employers.⁷ Relatedly, our national health expenditures have resumed their upward trajectory and are estimated to represent almost 20 percent of the country's gross domestic product before the end of the decade.⁸

COVID-19 clearly increased focus on the underinsurance problem, with questions almost immediately voiced as to whether the insured would have to suffer out-of-pocket expenditures for testing, treatment, or hoped-for vaccination. As the pandemic has worsened, attention is once again returning to access to healthcare in the U.S. which still only merits an "Incomplete." The cost and segmented nature of healthcare insurance remain the prevailing problems as persons churn from one insured (or uninsured) state to another, each with different premium and out-of-pocket-costs (some of which are unaffordable) and networks, many of which are narrow enough to generate surprise bills. COVID-19 has emphasized the unfinished work of the ACA, including the need for additional legislation to better integrate marketplaces with Medicaid to provide a more seamless insurance system for all.

⁶ See, e.g., CHRISTOPHER T. ROBERTSON, EXPOSED: WHY OUR HEALTH INSURANCE IS INCOMPLETE AND WHAT CAN BE DONE ABOUT IT (2019).

⁷ Sherry A. Glied and Benjamin Zhu, Catastrophic Out-of-Pocket Health Care Costs: A Problem Mainly for Middle-Income Americans with Employer Coverage (Commonwealth Fund, Apr. 2020). <https://doi.org/10.26099/x0cx-cp48>.

⁸ Sean P. Keehan et al., *National Health Expenditure Projections, 2019–28: Expected Rebound In Prices Drives Rising Spending Growth*, 34 HEALTH AFF. (Mar. 24, 2020).

The number of uninsured remains far too high, approaching 30 million,⁹ higher than the combined populations of Australia and New Zealand. From a high at the time the ACA was passed, the uninsured rate rapidly declined, only to begin increasing again over the last three years.¹⁰ The Trump Administration's lack of enthusiasm for the ACA marketplaces ("Obamacare"), the failure of some states to expand Medicaid, and the zeroing of the individual mandate penalty¹¹ must all bear some of the blame.

COVID-19 emphasizes the plight of the uninsured, such as those towards the bottom of the economic pyramid, those who are delivering our groceries and packages but are part-time employees without health insurance. One estimate suggests that hospitals treating the existing uninsured cohort will face uncompensated care in the range of \$13.9 billion to \$41.8 billion¹² with the high end of the estimate poised to consume over forty percent of funds set aside for hospitals by the CARES Act.¹³

Even more critically, the increasing economic toll of the pandemic will lead to millions of Americans losing both their jobs and their employer-provided health insurance. There is little guarantee that all—or even many—of these jobs will return. One study found that the number of people receiving employment-based coverage has already declined by 1.5 million and projects a

⁹ Jennifer Tolbert, Kendal Orgera, Natalie Singer & Anthony Damico, *Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Dec. 13, 2019), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/> (The estimate was 27.9 million in 2018).

¹⁰ Dylan Scott, *The uninsured rate had been steadily declining for a decade. But now it's rising again.*, VOX (Sep. 10, 2019), <https://www.vox.com/policy-and-politics/2019/9/10/20858938/health-insurance-census-bureau-data-trump>.

¹¹ Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081 (2017).

¹² Larry Levitt, Karyn Schwartz & Eric Lopez, *Estimated Cost of Treating the Uninsured Hospitalized with COVID-19*, KAISER FAM. FOUND. (Apr 07, 2020), <https://www.kff.org/uninsured/issue-brief/estimated-cost-of-treating-the-uninsured-hospitalized-with-covid-19/>.

¹³ Karyn Schwartz & Tricia Neuman, *A Look at the \$100 Billion for Hospitals in the CARES Act*, KAISER FAM. FOUND. (Mar. 31, 2020), <https://www.kff.org/coronavirus-policy-watch/a-look-at-the-100-billion-for-hospitals-in-the-cares-act/>.

further decline of 7.3 million and several million family members.¹⁴ Another estimate suggests a range of 12 to 35 million, with particularly high rates in states that have not expanded Medicaid.¹⁵

III. Healthcare Federalism is Overrated

Much of the angst displayed in state and federal briefings on COVID-19 has reflected a disagreement over whether the President or state governors have the power to order or rescind “shelter-in-place” orders. That federalism question is answered in the states’ favor by the 10th Amendment. *Healthcare* federalism, on the other hand, is considerably harder to pin down particularly after the Affordable Care Act, reflecting layers of intergovernmental dynamics, negotiations, and agreements.¹⁶ Whatever this federalism *is*, it does not promote coherent or consistent policies or, from the perspective of the patient, much that is understandable. Rather, the healthcare federalism built on top of our federal system of government has resulted in a dizzying array of actors, sources of finance, and reimbursement models. As already noted, each of these segments so created feature different rules governing access, benefits, out-of-pocket expenses, and so on.

According to Carl Ameringer, “The failure of the US government to construct a national health policy that reconciles diverse priorities means that there are no overriding principles to guide

¹⁴ Woolhandler S, Himmelstein DU. Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance. *Ann Intern Med*. 2020; [Epub ahead of print 7 April 2020]. doi: <https://doi.org/10.7326/M20-1491>.

¹⁵ HEALTH MANAGEMENT ASSOCIATES, COVID-19 IMPACT ON MEDICAID, MARKETPLACE, AND THE UNINSURED, BY STATE (Apr. 3, 2020), <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>.

¹⁶ Gluck AR, Huberfeld N. What Is Federalism in Healthcare For? *Stanford Law Rev*. 2018;70(6):1689–1803.

health care delivery.”¹⁷ Of course, there is preemptive, centralized regulation of, for example, drugs and healthcare privacy and, obviously, CMS administers Medicare and dictates considerable Medicaid policy. Overall, however, modern healthcare federalism together with the dominant role of private entities goes beyond separating healthcare financing from its delivery and has led to an incoherent mix of financing models and reimbursement policies.

During normal times, fiscal hawks frequently hold sway in Washington, seeking to reduce the federal healthcare financial footprint and threatening the most vulnerable with “reforms” such as work requirements and block grants.¹⁸ Outside of the norm, we see short term, additional funding during national emergencies such as the opioid overdose epidemic¹⁹ and, now, COVID-19.²⁰

Beyond these temporary occasions of generosity, the federal government has little enduring interest or ability in tackling major structural problems. For example, in a 2018 speech, HHS Secretary Azar recognized how little has been achieved in tackling the social determinants of health, highlighting the need to “do a better job of aligning federal health investments with our investments in non-healthcare needs.”²¹ Yet, he recognized that the structural impediments are massive; federal programs designed to help the vulnerable are spread across multiple agencies, frequently administered at the state level, and often are not even provided by government but depend on NGOs such as charities.

¹⁷ CALIFORNIA HEALTHCARE FOUNDATION, HEALTH CARE COSTS 101: A CONTINUING ECONOMIC THREAT 22 (May 2018), <https://www.chcf.org/wp-content/uploads/2018/05/HealthCareCosts2018.pdf>.

¹⁸ See generally Nicolas P. Terry, *Medicaid and Opioids: From Promising Present to Perilous Future*, TEMP. L. REV. at Parts III and IV (forthcoming 2020).

¹⁹ SUPPORT for Patients and Communities Act, Pub. L. No. 115-271 (2018).

²⁰ E.g., Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, Pub. L. No. 116-123 (2020) and Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136 (2020).

²¹ Alex M. Azar II, The Root of the Problem: America’s Social Determinants of Health, Hatch Foundation for Civility and Solutions (Nov. 14, 2018), <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html>.

While critics on the right like to refer to the ACA as a federal government takeover of healthcare, at most it was an expansion of health insurance regulation. Even given that limited frame, it was flawed because the shadow of ERISA continues to support regulatory fragmentation as states look to fill in the ACA's gaps.²²

Perhaps, the failure of federalism (both healthcare and public health), aided in large part by the Supreme Court in *Nat'l Fed'n of Indep. Bus. v. Sebelius*,²³ is best illustrated by the patchwork expansion of Medicaid that, once again, emphasized that where Americans live is likely determinative of their access to healthcare. As COVID-19 has spread from the cities to already underserved rural counties, the failure of some states to issue timely stay-at-home orders began to coalesce with the problem of large numbers of uninsured persons.²⁴ For too many, zip-code healthcare will morph into zip-code infection or mortality. To quote Nicole Huberfeld, "any assumption that states make better health choices is detached from history's lessons."²⁵

Even in what is beyond doubt a national emergency, the federal government has eschewed its leadership role. Indeed, frequently, the rhetoric of favoring "surgical" interventions is code for pushing the decision down to states or even localities. Worse, the federal government seems to

²² See generally Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. Penn. L. Rev. (forthcoming 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3395462

²³ 567 U.S. 519, 585 (2012).

²⁴ Molly Hennessy-Fiske & Jaweed Kaleem, *Will Texas or Florida be 'the next Italy'? Red states lag blue in stay-at-home orders*, L.A. TIMES (Mar. 23, 2020), <https://www.latimes.com/world-nation/story/2020-03-23/coronavirus-response-texas-florida-california-new-york?>

²⁵ Nicole Huberfeld, *Federalism in Health Care Reform*, in HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 198 (Ezra Rosser ed., 2019).

favor a Darwinian competition among states for scarce resources²⁶ or, worse, is blocking state access to some supplies.²⁷ As Washington Governor Jay Inslee complained about the federal government portraying its role as that of a backup, "Can you imagine if Franklin Delano Roosevelt said, 'I'll be right behind you, Connecticut, good luck building those battleships'?"²⁸

IV. Even Congress Knows "Trumpcare" is a Disaster

Although President Trump's administration and his congressional allies expended considerable energy on the idea of ACA "repeal and replace," the political reality of having to work within the budget reconciliation process left little room for "replace."²⁹ Thereafter, any plan the administration had would be executed through a combination of agency neglect and (de)regulation. Additionally, after the administration lost control of the House of Representatives (in no large part because the public had been warming to the ACA, particularly its ban on pre-existing condition clauses), explicit repeal was seldom mentioned, replaced with the false narrative that "It's dead. It's gone. You shouldn't even mention it. It's gone. There is no such thing as Obamacare anymore."³⁰

Thereafter, suspicions have been raised that the administration has been sabotaging the federal marketplace by reducing advertising and assistance to consumers, combined with system

²⁶ Nancy Cook & Dan Diamond, *'A Darwinian approach to federalism': States confront new reality under Trump*, POLITICO (Mar. 31, 2020), <https://www.politico.com/news/2020/03/31/governors-trump-coronavirus-156875>.

²⁷ David Wallace-Wells, *The White House Has Erected a Blockade Stopping States and Hospitals From Getting Coronavirus PPE*, New York, Apr. 19, 2020, <https://nymag.com/intelligencer/2020/04/hospitals-face-a-white-house-blockade-for-coronavirus-ppe.html>.

²⁸ Caroline Kelly, *Washington governor slams Trump administration for comparing coronavirus' grim outlook to Pearl Harbor*, WFSB (Apr. 5, 2020), https://www.wfsb.com/washington-governor-slams-trump-administration-for-comparing-coronavirus-grim-outlook-to-pearl-harbor/article_1946a8fb-79c9-53f2-8235-9c737b66fa74.html.

²⁹ Benjy Sarlin, *What is 'Repeal and Replace?' A Guide to Trump's Health Care Buzzwords*, NBC NEWS (Jan. 28, 2017), <https://www.nbcnews.com/news/us-news/what-repeal-replace-guide-trump-s-health-care-buzzwords-n713366>.

³⁰ Gambino, *supra* note 2.

downtimes for “maintenance” during key enrollment periods.³¹ More explicitly (if not legally³²), the administration ceased reimbursing insurers for the cost-sharing subsidies that the latter were obligated to pay to very low income marketplace customers, though the insurers got partial revenge by using what is known as “silver loading.”³³ Sadly, the Trump administration has decided against reopening the individual marketplace during the pandemic to absorb some of the new uninsured.³⁴

The administration’s main thrust over the last two years has been to create “choice” by introducing cheaper alternatives to the ACA’s individual market metallic plans that, if popular, likely would also weaken the ACA risk pools. Thus, the administration has promoted “skinny” plans such as Short-Term, Limited-Duration Insurance (STLD) and Association Health Plans (AHPs). STLD plans as modified by the Trump administration may last far longer than permitted under the ACA, do not have to provide essential health benefits, and can impose annual or lifetime limits.³⁵ AHPs predated the ACA and carry with them a dubious history of fraud and regulatory avoidance. Although a minor exception in the ACA permitted AHPs created by small businesses with common interests, the Trump Administration removed most of the limitations,³⁶ again allowing for policies that do not provide essential health benefits. Some states have already

³¹ Peter Sullivan, *Trump officials plan maintenance downtime for healthcare.gov during ObamaCare sign-ups*, THE HILL (Oct. 9, 2018), <https://www.thehill.com/policy/healthcare/410574-trump-officials-plan-maintenance-downtime-for-healthcaregov-during>.

³² See generally Katie Keith, *Latest Ruling Over Unpaid CSRs*, HEALTH AFF. (Oct. 25, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191025.570658/full/>.

³³ See generally Stan Dorn, *Silver Linings For Silver Loading*, HEALTH AFF. (Jun. 3, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190530.156427/full/>.

³⁴ Margot Sanger-Katz & Reed Abelson, *Obamacare Markets Will Not Reopen, Trump Decides*, N.Y. TIMES (Apr. 1, 2020), <https://www.nytimes.com/2020/04/01/upshot/obamacare-markets-coronavirus-trump.html>.

³⁵ Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212 (Aug. 3, 2018).

³⁶ Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912 (June 6, 2018).

moved to outlaw skinny plans³⁷ and the federal rule is being challenged in the courts.³⁸ There is also a dearth of data as to exactly what coverages skinny plans offer given the absence of essential health benefit or preexisting condition requirements.³⁹ There should be real concern that persons who were coaxed into buying these plans by the Trump Administration will now find themselves holding almost worthless policies when gauged against the likely costs of COVID-19 treatment beyond the initial testing.

The administration also continued to promote the Bush Administration model of HSAs combined with high deductible catastrophic plans. Finally, although it did not necessarily cause the problem of rapidly increasing out-of-pocket expenses and the attendant rise in the number of underinsured persons,⁴⁰ clearly the administration has done nothing to solve it.

As COVID-19 developed, Congress passed bipartisan legislation that implicitly ridicules some of these elements of “Trumpcare.” Thus, Section 6001 of the Families First Coronavirus Response Act requires that group, individual and grandfathered plans must provide coverage without cost-sharing for COVID-19 testing.⁴¹ However, STLD plans are not included, thus rendering their

³⁷ See, e.g., B. 1001, 22nd Council, Reg. Sess. (D.C. 2019) (defining short-term plans as nonrenewable & limited to 3 months); S.B. 1375, 2018 Leg., Reg. Sess. (Ca. 2018) (bars individuals from AHPs plans; bill author described plans as “junk insurance”). Cf. S.B. 322, 2019 Leg., Reg. Sess. (Fl. 2019) (specifically allows STLDs and AHPs).

³⁸ *New York v. US Dep’t of Labor*, 363 F.Supp. 3d 109 (D.D.C. 2019) (rejecting the department’s interpretation of ERISA and AHPs) app. filed, Apr. 30, 2019).

³⁹ Dania Palanker & Christina L. Goe, *States Don’t Know What’s Happening in Their Short-Term Health Plan Markets and That’s a Problem*, COMMONWEALTH FUND (Mar. 27, 2020), <https://www.commonwealthfund.org/blog/2020/states-dont-know-whats-happening-their-short-term-health-plan-markets-and-thats-problem>.

⁴⁰ *Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans*, COMMONWEALTH FUND (Feb. 7, 2019), <https://www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health>.

⁴¹ Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020).

members as uninsured and eligible for Medicaid coverage of the testing.⁴² Essentially, Congress announced that buying a skinny plan promoted by the administration was equivalent to being uninsured. As for high-deductible catastrophic plans, they too have had to be rethought in the light of the pandemic, and the IRS has advised that the plans can pay for COVID-19-related testing and treatment without jeopardizing their status.⁴³

As has been the case since the 2016 election, there is always a “new” Trumpcare plan around the corner. In late March 2020, the President hinted that he might use Medicare and Medicaid to cover the increased uninsured rate caused by the pandemic, saying “I’m not committing, I have to get approval. I’ve got a thing called Congress. It’s something to look at and we have been looking.”⁴⁴ However, it has been reported that such a plan is unpopular within the administration because it could undercut its political and legal positioning with regard to the *Texas v. U.S.* litigation.⁴⁵

V. Medicaid Has Never Been More Important

The 2017 repeal-and-replace arguments, particularly in the Senate, rotated around the most unpopular aspects of the ACA, such as the individual mandate. However, in the House of Representatives, then-Speaker Ryan was pursuing a parallel agenda: not just repealing Medicaid expansion but converting traditional Medicaid to a block grant program.⁴⁶ Although that effort

⁴² *Id.* at § 6004.

⁴³ IRS: High-deductible health plans can cover coronavirus costs, INTERNAL REVENUE SERV. (Mar. 11, 2020), <https://www.irs.gov/newsroom/irs-high-deductible-health-plans-can-cover-coronavirus-costs>.

⁴⁴ Susannah Luthi, *Trump hints at using federal programs to provide coverage after Obamacare decision*, POLITICO (Apr. 1, 2020), <https://www.politico.com/news/2020/04/01/trump-obamacare-coronavirus-160732>.

⁴⁵ *Id.*

⁴⁶ See, e.g., Shefali Luthra, *Everything You Need To Know About Block Grants — The Heart Of GOP’s Medicaid Plans*, KAISER HEALTH NEWS (Jan. 24, 2017), <https://khn.org/news/block-grants-medicaid-faq/>.

failed, the Trump Administration's CMS adopted a related agenda, also designed to reduce the Medicaid budget, but by reducing the number of eligible persons. This "work requirement" strategy, which was, at its philosophical core, an attempt to reframe Medicaid as welfare rather than health insurance, was to be implemented by approving Section 1115 waiver requests from states.⁴⁷ As is well-known, the administration's plans were put on ice by a combination of the shocking results in Arkansas, where 18,000 persons lost eligibility in six months, and legal challenges that culminated in a robust rejection of the program by the DC Circuit Court of Appeals.⁴⁸ With work requirements likely off the table, CMS turned to block grants, albeit after rebranding the initiative as a "Healthy Adult Opportunity."⁴⁹

It is Medicaid 101 that a recession, let alone one caused by an almost total shut down of economic life and vastly increased unemployment, will, in true counter-cyclical fashion, trigger increased demand for Medicaid, while state revenues decline.⁵⁰ However, COVID-19 provides further evidence that, in national health emergencies, Medicaid is an incredibly important initial response. For example, after Hurricane Katrina, the Bush administration removed the eligibility requirements for Medicaid benefits.⁵¹ Medicaid was also a major part of the federal government's response to the opioid overdose epidemic.⁵²

⁴⁷ Letter from Thomas E. Price, Sec'y, U.S. Dep't of Health & Hum. Servs., & Seema Verma, Adm'r, Ctrs. for Medicare and Medicaid Servs., to U.S. State Governors 1–2 (Mar. 14, 2017), <http://www.hhs.gov/sites/default/files/secpriceadminvermaltr.pdf>.

⁴⁸ *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020).

⁴⁹ Letter from Calder Lynch, Dir., Ctrs. for Medicare and Medicaid Servs., to State Medicaid Directors (Jan. 30, 2020), <http://www.medicaid.gov/sites/default/files/FederalPolicyGuidance/Downloads/smd20001.pdf>.

⁵⁰ See generally LAURA SNYDER & ROBIN RUDOWITZ, TRENDS IN STATE MEDICAID PROGRAMS: LOOKING BACK AND LOOKING AHEAD 4 (2016), <http://files.kff.org/attachment/Issue-Brief-Trends-in-State-Medicaid-Programs>.

⁵¹ *CMS Takes Emergency Steps To Ease Health Care Access To Katrina Evacuees*, CMS (Sep. 09, 2005), <https://www.cms.gov/newsroom/fact-sheets/cms-takes-emergency-steps-ease-health-care-access-katrina-evacuees>.

⁵² Letter from Brian Neale, Dir., Ctrs. for Medicare and Medicaid Servs., to State Medicaid Directors (Nov. 1, 2017), <http://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

The same has been true with COVID-19. Although CMS has resisted calls to follow the Bush model and liberalize eligibility, it has granted a large number of Section 1135 waivers that, for example, suspend prior authorization requirements or relax provider enrollment rules.⁵³ CMS has also begun approving Section 1115 waivers targeting specific COVID-19 needs.⁵⁴ The Families First Coronavirus Response Act provided COVID-19 testing for Medicaid recipients without cost-sharing⁵⁵ and introduced a temporary 6.2 percent increase in the FMAP, the federal government's contribution to Medicaid.⁵⁶

As if more evidence was needed, the pandemic has demonstrated the vital role that Medicaid plays in providing not only health care but also health resilience, normalizing access to services.⁵⁷ As already noted and doubling down on the cruel natural experiment⁵⁸ that was triggered by *Nat'l Fed'n of Indep. Bus. v. Sebelius*,⁵⁹ some non-expansion states also have governors who refused or delayed stay-at-home orders.⁶⁰

Medicaid provides another major role particularly in poor or rural areas. While reimbursement rates are not high, they are often what keeps rural hospitals afloat. One hundred and twenty rural

⁵³ See, e.g., *CMS Approves Medicaid Section 1135 Waivers for 11 Additional States in Response to COVID-19*, CMS (Mar. 23, 2020), <https://www.cms.gov/newsroom/press-releases/cms-approves-medicaid-section-1135-waivers-11-additional-states-response-covid-19>.

⁵⁴ CMS letter to Washington State Medicaid Director, April 21, 2020, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-covid19-phe-ca.pdf> (approving waiver to allow geographic and population targeting but denying request to establish a temporary eligibility group for individuals with incomes at or below 200 percent FPL).

⁵⁵ Families First Coronavirus Response Act § 6004.

⁵⁶ *Id.* at § 6008.

⁵⁷ Evan Goodenow, *Pandemic highlights value of Medicaid expansion in providing health care*, N. VA. DAILY (Mar. 29, 2020), https://www.nvdaily.com/nvdaily/pandemic-highlights-value-of-medicaid-expansion-in-providing-health-care/article_cea86582-3808-552a-b893-6d1aa45e9243.html.

⁵⁸ See e.g., Eyal Press, *A Preventable Cancer Is on the Rise in Alabama*, NEW YORKER (Mar. 30, 2020), <https://www.newyorker.com/magazine/2020/04/06/a-preventable-cancer-is-on-the-rise-in-alabama>

⁵⁹ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

⁶⁰ Margaret Renkl, *In the American South, a Perfect Storm Is Gathering*, N.Y. TIMES (April 3, 2020), <https://www.nytimes.com/2020/04/03/opinion/coronavirus-Tennessee-southern-states.html?>

hospitals have closed in the last decade, disproportionately in non-expansion states.⁶¹ Those that remain face existential challenges because of COVID-19 as their income from elective surgeries, physical therapy, and laboratory tests have all but disappeared.⁶² Laggard states adopting Medicaid expansion and increased Medicaid funding will be critical factors in providing healthcare over the next few years. The Surgeon General's 2016 report on addictions concluded that "Medicaid expansion is a key lever for expanding access to substance use treatment because many of the most vulnerable individuals with substance use disorders have incomes below 138% of the federal poverty level."⁶³ The same will be true during and after the current pandemic; as the vulnerable, poor, and persons of color suffer disproportionately, the program that benefits those groups the most must be strengthened.⁶⁴

Moneys provided under CARES Act are being distributed by CMS to hospitals in aid to compensate them for losses caused by the postponement of elective surgeries. However, more is needed. As urged by America's Health Insurance Plans and the Blue Cross Blue Shield Association, Congress should expand Medicaid to cover treatment in addition to testing and ensure that federal funds extend that coverage to the uninsured.⁶⁵ Those who fully understand the role that Medicaid plays in good times, and, particularly, in bad, have proposed reintroducing the

⁶¹ CHARTIS CTR. FOR RURAL HEALTH, CHARTIS GRP, THE RURAL HEALTH SAFETY NET UNDER PRESSURE: RURAL HOSPITAL VULNERABILITY, (2020), https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FINAL-02.14.20.pdf.

⁶² Lauren Weber, *Coronavirus Threatens The Lives Of Rural Hospitals Already Stretched To Breaking Point*, KAISER HEALTH NEWS (Mar. 21, 2020), <https://khn.org/news/coronavirus-threatens-the-lives-of-rural-hospitals-already-stretched-to-breaking-point/>.

⁶³ OFFICE OF THE SURGEON GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 6-7 (2016).

⁶⁴ See generally Barbara DiPietro, *Five Ways Medicaid Expansion Is Helping Homeless Populations Ten Years After The ACA Became Law*, HEALTH AFF. (Feb. 27, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200225.434660/full/>.

⁶⁵ Letter from Mitch McConnell, U.S. S. Majority Leader, to Nancy Pelosi, U.S. H. Speaker, Charles Schumer, U.S. S. Minority Leader, & Kevin McCarthy, U.S. H. Minority Leader (Mar. 19, 2020), <https://www.ahip.org/wp-content/uploads/AHIP-and-BCBSA-Legislative-Recommendations-03.19.2020.pdf>.

original ACA 100 percent enhanced match for three years to bring those holdout states into the fold.⁶⁶ Massive increases in the numbers of unemployed and uninsured will cement Medicaid as the most important healthcare insurance in the country and, hopefully, will reduce calls from the right for its dismemberment.

VI. The Private Sector is Overrated

The daily dueling televised briefings by the Trump administration and the nation's governors may have reflected disagreements over federal and state powers and responsibilities.⁶⁷ Under the surface, however, they also illustrate the fundamental fragility of a healthcare system that, some financing and regulation aside, is fundamentally one implemented by private actors interacting in a poorly functioning market model.

Those who tout the excellence of the U.S. healthcare, damning evidence to the contrary notwithstanding,⁶⁸ frequently look to markets and competition as the keys to innovation, cost reduction, and improved quality.⁶⁹ However, private healthcare entities (be they non-profits or for-profits) lack incentives to address the social determinants of health, to build community resilience, to construct wraparound service, or to invest in healthcare solidarity to achieve herd-based improvements to the health of all.

⁶⁶ Marianne Levine, *Dems eye Medicaid incentives for next coronavirus rescue package*, POLITICO (Apr. 7, 2020), <https://www.politico.com/news/2020/04/07/democrats-medicaid-incentives-coronavirus-rescue-package-173402>.

⁶⁷ Allan Smith, *'That woman from Michigan': Gov. Whitmer stands out in the pandemic. Just ask Trump*, NBC NEWS (Apr. 8, 2020), <https://www.nbcnews.com/politics/donald-trump/woman-michigan-gov-whitmer-stands-out-pandemic-just-ask-trump-n1170506>.

⁶⁸ Gerard F. Anderson & Bianca K. Frogner, *Health Spending In OECD Countries: Obtaining Value Per Dollar*, 27 HEALTH AFF. (2008).

⁶⁹ Seema Verma, Adm'r, Ctrs. for Medicare and Medicaid Servs., Remarks to the Centers for Consumer Information and Insurance Oversight's Industry Day (Jan 29, 2020), <https://www.cms.gov/newsroom/press-releases/cms-administrator-seema-vermas-remarks-centers-consumer-information-and-insurance-oversights-cciiios>.

Of course, there are regulatory “nudges,” such as the ACA’s Hospital Readmissions Reduction Program⁷⁰ and the requirement that non-profit hospitals perform community health needs assessments.⁷¹ However, these seem to have had little impact on our deep structural problems. These are problems that require centralized intervention and are not issues addressable by the private actors in our deeply fragmented healthcare system or, as argued above, most of our states. Take, for example, rural populations, which continue to see their healthcare needs rise while their hospital and provider resources are hollowed out.⁷² Medicaid expansion⁷³ and DSH payments⁷⁴ help, but only centralized government can sustain a comprehensive rural healthcare system.

COVID-19 not only illustrates how private actors failed to invest in prophylactic structures but also their relatively poor performance once the pandemic arrived. For example, stories have emerged of chaotic responses by for-profit private healthcare systems that were reducing supplies and overworking staff even before the virus hit.⁷⁵ Reliance on diffuse private entities who are also competitors is also responsible for much of the fragmentation in our healthcare system. As the situation in New York worsened in March 2020, Governor Cuomo announced a

⁷⁰ Sec. 3025 (2010).

⁷¹ Sec. 9007 and 26 C.F.R. §1.501(r)-3 (2020).

⁷² Jaime Rosenberg, *Understanding the Health Challenges Facing Rural Communities*, AJMC (Feb. 05, 2019), <https://www.ajmc.com/conferences/academyhealth-2019/understanding-the-health-challenges-facing-rural-communities>.

⁷³ Adam Searing, *More Rural Hospitals Closing in States Refusing Medicaid Coverage Expansion*, GEO. U. HEALTH POL. INST. (Oct. 29, 2018), <https://ccf.georgetown.edu/2018/10/29/more-rural-hospitals-closing-in-states-refusing-medicaid-coverage-expansion/>.

⁷⁴ Michael Ollove, *Rural and Safety Net Hospitals Prepare for Cut in Federal Support*, PEW TR. (Oct. 31, 2019), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/10/31/rural-and-safety-net-hospitals-prepare-for-cut-in-federal-support>.

⁷⁵ Desmond Butler, *Anguished nurses say Pennsylvania hospital risked infecting cancer patients, babies and staff with covid-19*, WASH. POST (Apr. 11, 2020), <https://www.washingtonpost.com/health/2020/04/11/amid-chaos-anguished-nurses-say-pennsylvania-hospital-risked-infecting-cancer-patients-babies-staff/?arc404=true>.

statewide public-private hospital plan to fight COVID-19. This essentially merged the 200 entities, allowing them to share supplies and staff and balance capacity.⁷⁶

The negatives inherent in the U.S. private system extend beyond delivery to financing. For example, when a system is designed around third-party reimbursement, it may have to shutter and furlough staff during a national emergency—a peculiar irony as hospital staff are let go during a time when our healthcare resources are overwhelmed.⁷⁷ Equally, the friction caused by the interaction of private insurance companies and providers is brought into stark relief during a pandemic, when quick responses; innovation in delivery, such as using tele-health; and speedy authorization are missing.⁷⁸ COVID-19 has magnified the dysfunction inherent in the public-private model, such as when vindictive politicians instruct suppliers not to send needed supplies to a particular state.⁷⁹

Needless to say, generalizations are never perfect. A public, top-down, integrated system also will falter in the face of a pandemic if the chosen strategy is flawed, as has been the case in the United Kingdom.⁸⁰ However, in general, Western democracies have favored less reliance on

⁷⁶ Office of N.Y. Governor Andrew Cuomo, *Amid Ongoing COVID-19 Pandemic, Governor Cuomo Announces Statewide Public-private Hospital Plan to Fight COVID-19*, N.Y. ST. (Mar. 30, 2020), <https://www.governor.ny.gov/news/amid-ongoing-covid-19-pandemic-governor-cuomo-announces-statewide-public-private-hospital-plan>.

⁷⁷ Associated Press, *A Mounting Casualty of Coronavirus Crisis: Health Care Jobs*, N.Y. TIMES (Apr. 4, 2020), <https://www.nytimes.com/aponline/2020/04/04/business/ap-us-virus-outbreak-hospital-layoffs.html>; Bill Estep & Will Wright, *Kentucky hospital chain furloughs about 500 employees as coronavirus saps business*, LEXINGTON HERALD LEADER (Mar. 27, 2020), <https://www.kentucky.com/news/coronavirus/article241565211.html>.

⁷⁸ Ankita Rao, *US private health insurance companies clog system amid Covid-19 pandemic*, GUARDIAN (Mar. 26, 2020), <https://www.theguardian.com/us-news/2020/mar/26/us-insurance-companies-coronavirus-hospitals>.

⁷⁹ Chad Livengood, *Whitmer: Feds told vendors not to send medical supplies to Michigan*, CRAIN'S DETROIT BUS. (Mar. 27, 2020), <https://www.craigslistdetroit.com/coronavirus/whitmer-feds-told-vendors-not-send-medical-supplies-michigan>.

⁸⁰ Richard Horton, *COVID-19 and the NHS—“a national scandal”*, 395 LANCET 1022 (2020).

private healthcare during the COVID-19 pandemic. For example, the public health systems in Ireland⁸¹ and Spain⁸² took over private providers for the duration of the pandemic.

If there is one overarching lesson to be learned from COVID-19, it is that the country's investments in clinical care versus public health must be recalibrated. The inevitable barrier to that reform will be private healthcare's lobbyists who will argue for increased reimbursement for providers rather than channeling resources to social determinants, surveillance, and preventive care.

VII. Conclusion

History likely will record the COVID-19 pandemic as a once-in-a-century disaster, but that should not absolve the U.S. healthcare system from blame. The last few decades have provided multiple previews of the system's deficiencies and structural weaknesses that render it even less able to sustain a crisis: from Hurricane Katrina in 2005, to H1N1 in 2009, to the Ebola virus in 2014, and the height of the opioid overdose epidemic beginning in 2011. Some will argue that the loss of life seen in Italy, Spain, and the United Kingdom prove that a universal-coverage, single-payer system is not necessarily the solution for the United States.⁸³ More thoughtful analysis will conclude, however, that the pandemic exposed the deep flaws in our healthcare

⁸¹ Órla Ryan, *Private hospitals will be made public for duration of coronavirus pandemic*, JOURNAL.IE (Mar. 24, 2020), <https://www.thejournal.ie/private-hospitals-ireland-coronavirus-5056334-Mar2020/>.

⁸² Oriol Güell & Inés Santaaulalia, *Spanish government puts private healthcare firms at the orders of the regions*, EL PAÍS (Mar. 16, 2020), <https://english.elpais.com/society/2020-03-16/spanish-government-puts-private-healthcare-firms-at-the-orders-of-the-regions.html>.

⁸³ Ramesh Ponnuru, *Italy Shows That Medicare for All Is No Cure for Coronavirus*, Bloomberg (Mar. 17, 2020), <https://www.bloomberg.com/opinion/articles/2020-03-17/coronavirus-italy-shows-medicare-for-all-is-no-cure> (discussing Sanders-Biden colloquy during Democratic primary debate).

system,⁸⁴ flaws that flow from a healthcare financing system that reflects individualism rather than solidarity. Those flaws were tragically encapsulated in a story related by a nurse anesthetist in New York City who memorialized the dying words of one of his COVID-19 patients as he was placed on a ventilator: “Who's going to pay for it?”⁸⁵

⁸⁴ Dylan Scott, *Coronavirus is exposing all of the weaknesses in the US health system*, VOX (Mar. 16, 2020), <https://www.vox.com/policy-and-politics/2020/3/16/21173766/coronavirus-covid-19-us-cases-health-care-system>.

⁸⁵ Alaa Elassar, *A nurse revealed the tragic last words of his coronavirus patient: 'Who's going to pay for it?'*, CNN (Apr. 11, 2020), <https://www.cnn.com/2020/04/11/health/nurse-last-words-coronavirus-patient-trnd/index.html>.